Grand Rapids Pain

Name: _____ Date of Birth: _____ Patient ID: _____
Last First MI

Authorization for Specific Confidential Communications

I authorize my physician and/or administrative and clinical staff to disclose the following protected health information to:

Name: _____ Relationship to Patient _____
Name: _____ Relationship to Patient _____
Name: _____ Relationship to Patient _____
Name: _____ Relationship to Patient _____

Select the Protected Health Information to be used or disclosed to the above listed individual(s) from the list below:

o Medical Care / Treatment: **Yes ___ No ___** **Level of Information** _____
o Billing Information **Yes ____ No ____**
o Pick up PHI: (such as prescriptions, billing statements, labs etc.) **Yes ___ No ___**
o Other (specify in detail – such as date of service, type of service, level of detail to be released, origin of information etc.) _____
_____

This authorization shall be in force and effect and does not expire until it is revoked in writing. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact at: Grand Rapids Pain, 4024 Park East Court SE, Grand Rapids, MI 4946. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I request that all communications to me (by telephone, mail, etc.) by Grand Rapids Pain. and/or its staff be handled in the following manner:

* For **written** communications: Address to: _____

* For **oral** communications: Call: _____ May we leave a message? YES ☐ NO ☐
(telephone number)

If the above address is not a street address or is not your home address, please provide us with a (home) street address for purposes of ensuring payment:

_____
(street number and address) City State Zip

_____ _____/_____/_____
Patient Signature Date

_____ _____/_____/_____
Parent/Guardian Signature Date

**Needed for alternative written or oral communication listed in above box only.*
For Practice Use Only: Practice: Accepts ☐ Denies ☐

Privacy Officer's Signature _____ Date: _____